APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10831

ROBERT ROARK; Robert Roark, on Behalf of the Estate of Gwen Roark, Plaintiffs-Appellants,

v.

HUMANA, INC.; Humana Health Plan of Texas, Inc., Doing Business as Humana Health Plan of Texas (Dallas), Doing Business as Humana Health Plan of Texas (San Antonio), Doing Business as Humana Health Plan of Texas (Corpus Christi); Humana HMO Texas, Inc., Defendants-Appellees.

Case No. 01-10891

RUBY R. CALAD, Plaintiff-Appellant-Cross-Appellee,

and

WALTER PATRICK THORN, Plaintiff-Cross-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INCORPORATED, Doing Business as Healthsource, Doing Business as Cigna Corporation, Defendant-Appellee,

AETNA U.S. HEALTHCARE; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants-Appellees-

Cross-Appellants.

No. 01-10905

JUAN DAVILA, Plaintiff-Appellant,

v.

AETNA U.S. HEALTHCARE, INC.; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants-Appellees.

Sept. 17, 2002.

Appeals from the United States District Court for the Northern District of Texas, Dallas.

Before SMITH, BENAVIDES and PARKER, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

This suit consolidates multiple district court actions and appeals for consideration of common issues. Ruby Calad, Walter Thorn, Juan Davila, and Gwen Roark sued their respective health maintenance organizations ("HMO's") for negligence under Texas state law: They alleged that although their doctors recommended treatment, the HMO's negligently refused to cover it. The HMO's removed to federal court, arguing that because each plaintiff received HMO coverage through his employer's ERISA plan, the claims arose under ERISA. The plaintiffs moved to remand.

The respective district courts denied Calad, Davila, and

Roark's remand motions and dismissed their claims under Fed.R.Civ.P. 12(b)(6), citing ERISA preemption. The district court granted Thorn's remand motion. Roark, Calad, and Davila appeal the refusal to remand and, in the alternative, the dismissal. Thorn's HMO appeals the remand. We affirm the judgments in Roark's and Thorn's cases and reverse with respect to Calad and Davila.

I.

A. Ruby Calad

Through her husband's employer, Calad became a member of CIGNA HealthCare of Texas, Inc. ("CIGNA"), a Texas HMO. Calad underwent a hysterectomy with rectal, bladder, and vaginal repair. The surgery was performed by a CIGNA physician. Although that doctor recommended a longer stay, CIGNA's hospital discharge nurse decided that the standard, one day hospital stay would be sufficient. Calad suffered complications that returned her to the emergency room a few days later; she attributes these complications to her early release.

Calad sued in state court under the Texas Health Care Liability Act ("THCLA"),[1] alleging CIGNA had failed to use ordinary care in making its medical necessity decisions, CIGNA's system made substandard care more likely, and CIGNA acted negligently when it made its medical necessity decisions. CIGNA removed to federal court based on ERISA preemption. Calad moved to remand, but the court denied the motion. The court noted "that Calad has repeatedly made clear that, should the Court deny her motion to remand, she will not amend her pleading to bring an ERISA claim and therefore requests that her claims be dismissed."

---

[1] Tex. Civ. Prac. & Rem.Code § § 88.001-88.003.

Accordingly, the court dismissed under rule 12(b)(6).

B. Walter Thorn

Thorn received Aetna U.S. Healthcare insurance through his employer. He injured his hand in a car accident, and doctors amputated his ring finger. The doctors said he needed surgery in two to three days, or he would lose his hand. An Aetna-designated specialist scheduled the surgery for the next day.

A few hours before the scheduled surgery, Aetna refused to authorize its surgeon to operate. While Aetna reviewed the case, it sent a physical therapist to help exercise Thorn's hand, so it would not deteriorate while Thorn waited for surgery. Aetna eventually approved the surgery, but Thorn contends that Aetna's delay caused scarring that has diminished his manual mobility.

Thorn sued jointly with Calad. Initially, Calad and Thorn alleged that CIGNA and Aetna were jointly and severally liable. They later withdrew this allegation, explaining it was a pleading error. Thus, Calad's claims run only against CIGNA, and Thorn's runs only against Aetna. CIGNA removed to federal court (with Aetna's consent), citing ERISA preemption. Thorn moved to remand, arguing that ERISA excludes government plans such as his from preemption. The district court remanded Thorn's claim.

C. Juan Davila

Davila is a post-polio patient who suffers from diabetes and arthritis. He received Aetna HMO coverage through his employer's health plan. His primary care physician pre-

scribed Vioxx for Davila's arthritis pain. Studies have shown that Vioxx has a lower rate of gastrointestinal toxicity (e.g., bleeding, ulceration, perforation of the stomach) than do the other drugs on Aetna's formulary. Before filling the prescription, Aetna required Davila to enter its "step program": Davila first would have to try two different medications; only if he suffered a detrimental reaction to the medications or failed to improve would Aetna evaluate him for Vioxx use.

As part of the step program, Davila first was given naprosyn (a cheaper pain reliever). After three weeks, he was rushed to the emergency room. The doctors reported he suffered from bleeding ulcers, which caused a near heart attack and internal bleeding. The doctors gave Davila seven units of blood and kept him in critical care for five days. Now he cannot take any pain medication that is absorbed through the stomach.

Davila sued in state court under the THCLA, alleging Aetna had failed to use ordinary care in making medical necessity decisions, Aetna's systems made substandard care more likely, and Aetna acted negligently in making its medical necessity decisions. Aetna removed to federal court, citing ERISA preemption.

Davila moved to remand. The court concluded that some of Davila's claims were completely preempted under ERISA § 502(a) and thus denied remand. The court noted that normally it would dismiss Davila's state law claims and grant him leave to file an amended complaint under ERISA. But, because Davila had informed the court he would not pursue an ERISA claim, it instead dismissed with prejudice under rule 12(b)(6).

D. Gwen Roark

In 1990, Roark was bitten by what was believed to be a brown recluse spider. The bite damaged the skin, muscle, and bone of her left leg, requiring antibiotics, three skin graft operations, and two surgeries to create "free flaps" over her wound. In 1997, Roark began using a vacuum-assisted closure device ("VAC") to circulate blood to the skin's surface and quicken healing. Each day, a nurse came to Roark's home and spent two hours scraping the wound with a scalpel; Roark wore the VAC for the other twenty-two hours of the day.

Later that year, Humana Health Plan of Texas ("Humana") became the Roarks' HMO. Roark's primary care physician recommended she continue using the VAC and authorized treatment. In 1998, Humana delayed the VAC treatments and home nursing several times; upon each delay, Roark filed an immediate appeal or grievance. The primary care physician told Humana that without the VAC and home nursing case, Roark could lose her leg. Humana eventually approved the VAC for ninety days. Humana periodically delayed VAC and home nursing treatment until December 1998, when it cancelled home nursing altogether. Humana agreed to pay only for visits to a local hospital's wound center.

In February 1999, Roark developed a serious infection that required the doctors to amputate her leg that March. While Roark was convalescing, Humana again denied her VAC treatment that may have helped heal the amputation wound. In January 2000, the doctors performed an additional amputation treatment on her leg.

Roark and her husband Robert sued in state court under the THCLA, the Texas Deceptive Trade Practices Act ("DTPA")[2] the Texas Insurance Code,[3] and common law

---

[2] Tex. Bus. & Com.Code § 17.46(a), (b)(5), (b)(12).

[3] Tex. Ins.Code art. 21.21 § § 4(1), (2), (11)(a), (11)(c).

breach of good faith, fair dealing, and contract. Humana removed to federal court, citing ERISA preemption. The Roarks moved to remand. The court found that the Roarks' DTPA and insurance claims were completely preempted under ERISA § 502(a) and thus denied the motion.

The Roarks then amended their complaint to allege only violations of the THCLA--that Humana had failed to use ordinary care when it made its medical necessity decisions, Humana's system made substandard care more likely, and Humana was negligent in making its medical necessity decisions--and filed a second remand motion. The court held that ERISA § 502(a) preempts the THCLA claim as well, denied the Roarks' motion to remand, and dismissed under rule 12(b)(6).

The court gave the Roarks thirty days to replead under ERISA § 502(a), failing which their case would be dismissed with prejudice under rule 12(b)(6). The Roarks declined and filed this appeal challenging the second remand order. The district court never entered the final order dismissing the case with prejudice under rule 12(b)(6), but it did list the case closed for statistical purposes. The Roarks' notice of appeal also states that they will not replead under ERISA.

II.

A. Calad's and Davila's remand motions

With exceptions not relevant here, "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a).

If, before final judgment, it appears the case was not properly removed because it was not within the federal courts' original jurisdiction, the district court must remand. 28 U.S.C. 1447(c).

The "well-pleaded complaint rule" limits federal courts' original jurisdiction to those cases in which the plaintiff's complaint states a cause of action arising under federal law; a federal defense will not do. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust,* 463 U.S. 1, 9-10, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983) (citing *Louisville & Nashville R.R. v. Mottley,* 211 U.S. 149, 29 S.Ct. 42, 53 L.Ed. 126 (1908)). "[S]ince 1887 it has been settled law that a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case." *Franchise Tax Bd.,* 463 U.S. at 13-14, 103 S.Ct. 2841.

Calad and Davila advance only state law causes of action; a straightforward application of the well-pleaded complaint rule would deprive the federal courts of original and removal jurisdiction over their claims. But, we recognize an exception to the well-pleaded complaint rule for those few statutes whose "preemptive force ... is so powerful as to displace entirely any state causes of action." *Id.* at 23, 103 S.Ct. 2841. Where "a federal cause of action completely preempts a state cause of action, any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 24, 103 S.Ct. 2841. Such actions are excepted from the well-pleaded complaint rule and confer original and removal jurisdiction. *Metro. Life Ins. Co. v. Taylor,* 481 U.S. 58, 65- 66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987); *Giles v. NYLCare Health Plans, Inc.,* 172 F.3d 332, 336 (5th Cir.1999). The Supreme Court first recognized this exception for § 301 of the Labor-Management Relations Act

("LMRA")[4] and has extended the rule to some, but not all, cases under ERISA.[5]

ERISA provides two types of preemption: complete preemption under § 502(a) and conflict preemption under § 514. *Giles,* 172 F.3d at 336; *McClelland v. Gronwaldt,* 155 F.3d 507, 515-17 (5th Cir.1998). "Section 502, by providing a civil enforcement cause of action, completely preempts any state cause of action seeking the same relief." *Id.* at 337.

Section 502(a) complete preemption is a slight misnomer, for it does not involve traditional preemption analysis. *McClelland,* 155 F.3d at 516 ("Complete preemption is less a principle of substantive preemption than it is a rule of federal jurisdiction."). We do not ask whether the state law conflicts with or frustrates a congressional purpose, but whether the state law duplicates or "falls within the scope of" an ERISA § 502(a) remedy. *Taylor,* 481 U.S. at 64, 107 S.Ct. 1542; *McClelland,* 155 F.3d at 518. If Calad and Davila could have brought their claims under ERISA § 502(a), the claims would be completely preempted, and the district court would have been correct to exercise jurisdiction.

Section 514, in contrast, provides for ordinary conflict preemption.[6] State law claims that fall outside § 502(a), even though preempted by § 514, follow the well-pleaded complaint rule and do not confer original or removal jurisdiction. *Franchise Tax Bd.,* 463 U.S. at 23-27, 103 S.Ct. 2841; *Giles,* 172 F.3d at 337.

---

[4] *Avco Corp. v. Aero Lodge No. 735,* 390 U.S. 557, 88 S.Ct. 1235, 20 L.Ed.2d 126 (1968); *see also Franchise Tax Bd.,* 463 U.S. at 23, 103 S.Ct. 2841.

[5] *Metropolitan Life,* 481 U.S. at 64-65, 107 S.Ct. 1542.

[6] ERISA § 514(a) preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a).

We review the district court's preemption analysis, which formed the basis for its subject matter jurisdiction, *de novo*. *McClelland v. Gronwaldt,* 155 F.3d 507, 511 (5th Cir.1998). Because we conclude that § 502(a) does not displace Calad's or Davila's claims, the district court should have remanded.

The enforcement provisions listed in ERISA § 502(a)(5)-(9) do not provide a cause of action for participants and beneficiaries; because Davila is an ERISA participant[7] and Calad is an ERISA beneficiary[8] neither could have asserted a claim that falls within these subsections.[9] Subsections 502(a)(1)(A) and (4) deal with plan administrators' duties to supply information; they too are irrelevant. Section 502(a)(3) indicates equitable remedies are generally available under ERISA; it includes only "those categories of relief that were typically available in equity," *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 122 S.Ct. 708, 712, 151 L.Ed.2d 635 (2002), not the damages claims Calad and Davila bring, *id.* at 713. This leaves only two enforcement provisions of § 502(a)[10] --§ 502(a)(2) and (a)(1)(b)--

---

[7] *See* 29 U.S.C. § 1002(7) ("The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization").

[8] *See* 29 U.S.C. § 1002(8) ("The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder").

[9] *Cf. McClelland,* 155 F.3d at 518.

[10] In its entirety, § 502(a) reads,

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance

neither of which preempts Calad's or Davila's claims.

1. § 502(a)(2)

Calad and Davila argue that their HMO's were not acting as plan fiduciaries when denying them medical treatment, so § 502(a)(2) cannot cover (or completely preempt) their THCLA claims. We agree.

Section 502(a)(2) allows a plan participant or beneficiary to sue "for appropriate relief under section 1109 of this title." 29 U.S.C. § 1132(a)(2). Section 1109(a) in turn provides:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach
>
> ....
>
> 29 U.S.C. § 1109(a).

In *Pegram v. Herdrich,* 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000), the Court decided that under § 502(a)(2), a patient cannot hold his HMO vicariously liable for its physician's medical malpractice. Although *Pegram* did not decide the precise question before us--whether, under § 502(a)(2), a patient can hold his HMO *directly* liable for its own medical malpractice--its holding is broad enough to apply here.

---

contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. 1132(a).

In *Herdrich,* the plaintiff became a patient of Pegram's through her HMO. When Pegram discovered an inflamed mass in Herdrich's abdomen, she did not order an immediate ultrasound; instead, she decided Herdrich would have to wait eight days to be examined at a center fifty miles away; in the meantime, Herdrich's appendix ruptured.

Herdrich sued Pegram for medical malpractice and sued both Pegram and her HMO under ERISA § § 502(a)(2) and 1109, alleging that the HMO's medical rationing scheme, by which it "reward[ed] its physician owners for limiting medical care, entailed an inherent breach of an ERISA fiduciary duty, because these terms created an incentive to make decisions in the physicians' self- interest rather than in the exclusive interest of the plan participants." *Pegram,* 530 U.S. at 216, 120 S.Ct. 2143.

The Court unanimously ruled that Herdrich did not state a cause of action under § 502(a). The Court first categorized Herdrich's claim. HMO's, it explained, made three types of decisions--eligibility decisions, treatment decisions, and mixed eligibility and treatment decisions. *Id.* at 228-29, 120 S.Ct. 2143. Eligibility decisions "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Id.* at 228, 120 S.Ct. 2143.

Pure eligibility decisions, "simple yes-or-no questions, like whether appendicitis is a covered condition," are likely rare. *Id.* Treatment decisions, "by contrast, are choices about how to go about diagnosing and treating a patient's condition." *Id.* Herdrich's case, the Court concluded, involved "the more common" mixed decision, such as "whether one treatment option is so superior ... and needed so promptly, that a decision to proceed would meet the medical necessity requirement." *Id.* at 228-29, 120 S.Ct. 2143. Claims regarding such "mixed eligibility and treatment decisions," the Court held, do not fall within § 502(a)(2). *Id.* at 231-32, 120 S.Ct. 2143.

It seems beyond dispute that Calad's and Davila's claims involve such mixed decisions. CIGNA agrees its plan covers hospital stays after a hysterectomy, and Aetna agrees its plan includes a range of arthritis drugs, so we are not presented with simple yes-or-no coverage questions. Instead, we are presented with the type of "when and how" medical necessity questions--whether Calad was provided enough treatment (enough days in the hospital) and whether Davila was prescribed the correct treatment (naprosyn instead of Vioxx)--that fall within *Pegram* 's rule. *Id.* at 228-29, 120 S.Ct. 2143.

Pegram is distinguishable in one regard: Herdrich claimed her doctor made the erroneous medical decision; Calad and Davila claim their HMO's did. But *Pegram* 's reasoning indicates this distinction is immaterial to the § 502(a)(2) analysis.

The *Pegram* Court expressed doubt that "that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* at 231, 120 S.Ct. 2143. It contrasted fiduciaries, who must "act solely in the interest of the patient without possibility of conflict," *id.* at 233, 120 S.Ct. 2143, with HMO's, whose entire purpose is to balance costs against patient welfare, *id.* at 231-32, 120 S.Ct. 2143. "Since inducement to ration care goes to the very point of any HMO scheme," *id.* at 221, 120 S.Ct. 2143, treating HMO's as ERISA fiduciaries would entail "nothing less than the elimination of the for-profit HMO," *id.* at 233, 120 S.Ct. 2143.

The *Pegram* Court went on to note the potential "mischief" the alternative holding would entail. *Id.* at 236, 120 S.Ct. 2143. Such a rule would create a federal body of malpractice law applicable against HMO's and physicians. *Id.* at 235-36, 120 S.Ct. 2143. And, because ERISA § 502(a) preempts any overlapping state law, this would create "a puzzling issue of preemption"; it "would seem to be a prescription for preemption of state malpractice law." *Id.* at 236, 120

S.Ct. 2143. This could not be so, the Court explained, for "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose," *id.* at 237, 120 S.Ct. 2143 (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995)), and it was unimaginable that Congress intended ERISA to create a federal common law of medical malpractice. *Id.*

These factors apply with equal force to a claim that an HMO breached its fiduciary duty in denying care. Such a claim demands that the HMO forego its core purpose--rationing care--and act only in the patient's interest. And, such a claim would create a federal body of malpractice law applicable against HMO's. Because *Pegram* is indistinguishable, § 502(a)(2) does not completely preempt Calad's and Davila's THCLA claims.

2. § 502(a)(1)(B)

The Supreme Court has declined to decide whether § 502(a)(1)(B) displaces a medical malpractice claim involving "mixed decisions," *Pegram*, 530 U.S. at 229 n. 9, 120 S.Ct. 2143, and this circuit has not yet confronted the question.[11] We now conclude that § 502(a)(1)(B) does not pre-

---

[11] In *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.1992), we held that § 514 preempted a patient's claim that her HMO was medically negligent for refusing to hospitalize her. Section 502(a) preemption is a subset of § 514 preemption. Although any claim that falls within § 502(a) necessarily falls within § 514, claims that fall under § 514 do not necessarily fall under § 502(a). *McClelland*, 155 F.3d at 517. Thus, *Corcoran* does not decide our question.

In *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 535 (5th Cir.2000), *vacated on other grounds by Montemayor v. Corporate Health Ins.*, --- U.S. ----, 122 S.Ct. 2617, 153 L.Ed.2d 800 (2002), we ruled that § 514 (and thus § 502(a)(1)(B)) does not preempt a

empt Calad's and Davila's THCLA claims.

Section 502(a)(1)(B) allows a plan participant or beneficiary to bring a civil action "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Calad's and Davila's claims of HMO medical malpractice differ fundamentally from the § 502(a)(1)(B) claims we have recognized. Section 502(a)(1)(B), we have held, creates a cause of action for breach of contract: When a plan administrator incorrectly interprets the plan to deny benefits, the patient may sue to recover the benefits.[12] By contrast, Calad and Davila assert tort claims; they have not sued their ERISA plan administrator, nor do they challenge his interpretation of the plan.

Dowden v. Blue Cross & Blue Shield, Inc., 126 F.3d 641 (5th Cir.1997) (per curiam), is on point. The plaintiff's health insurer refused to cover the expenses she incurred treating complications from breast implants. The insurance policy limited coverage to only "medically necessary" treatments, and the plan administrator concluded that Dowden's treatment did not fit the plan's definition. *Id.* at 644. Dowden sued under § 502(a)(1)(B), claiming "the plan adminis-

---

THCLA suit holding an HMO vicariously liable for its doctor's negligence. But we cannot automatically extend *Corporate Health* 's holding to suits directly against an HMO. The *Corporate Health* court held that when a doctor denies treatment, he makes a quality-of-care decision, which escapes ERISA preemption. By contrast, when an HMO denies treatment, it makes a coverage decision, and claims over such a decision are preempted by ERISA. *Id.* at 534-35 & n. 24. *But cf. Pegram*, 530 U.S. at 228-30, 120 S.Ct. 2143 (indicating courts should look to the substance of the decision, not the identity of the decisionmaker, in determining whether ERISA applies).

[12] *See, e.g., Gosselink v. Am. Tel. & Telegraph, Inc.*, 272 F.3d 722, 726-28 (5th Cir.2001); *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 636 (5th Cir.), *modified*, 979 F.2d 1013 (5th Cir.1992).

trator abused its discretion in interpreting the term 'medically necessary' as expressly defined in the insurance contract," and wrongfully withheld benefits owed to her. *Id.* at 643.

Superficially, this claim resembles Calad's and Davila's: Like Calad and Davila, Dowden claimed she was wrongfully denied medically necessary treatment. But, Dowden asserted a contract claim for contract damages; Calad and Davila assert a tort claim for tort damages. Calad and Davila are not seeking reimbursement for benefits denied them: Calad is not requesting the value of an extra night at the hospital, and Davila is not requesting reimbursement for the more expensive drug the HMO denied.

In deciding Dowden's claim, we were limited to the plan and its definition of "medically necessary." For Calad and Davila, the wording of their plans is immaterial; they invoke an external, statutorily imposed duty of "ordinary care."

Furthermore, this court has treated as given that ERISA provides no cause of action for medical malpractice claims against an HMO. In *Corcoran* we noted the troubling result of our holding that ERISA § 514 bars states from providing such remedies: "The result ERISA compels us to reach means that the [plaintiffs] have no remedy, state or federal, for what might have been a serious mistake."[13] Nor have we ever recognized a claim of HMO medical negligence under § 502(a)(1)(B).

The Third Circuit has reached the same conclusion. In *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir.1995), the court held that claims that an HMO had failed to exercise reasonable care in providing medical treatment are not completely preempted by § 502(a)(1)(B). The plaintiff complained that her hospital provider had acted negligently in delaying her husband's blood test. This delay led to

---

[13] *Corcoran*, 965 F.2d at 1338; accord *id.* at 1333; Note, *Recent Cases*, 114 HARV. L.REV. 1406, 1409 (2001).

a late diagnosis of his condition and, she argued, his untimely death. *Id.* Her HMO, she asserted, was vicariously liable for the hospital's malpractice and directly liable for negligence in selecting its medical service providers.

Such a claim, the court explained, was not completely preempted, because it "merely attacked the *quality* of benefits received." *Id.* at 356. "Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies on [her husband] because the ERISA plan refused to pay for the studies." *Id.* at 357.

The Third Circuit's more recent decision in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir.2001), reaffirms this conclusion. The plaintiff claimed, *inter alia*, that her HMO " 'negligently and carelessly delayed in giving its approval for the necessary surgery which the plaintiff ... urgently needed.' " *Id.* at 270 (alterations in original). Although the court held that ERISA § 502(a)(1)(B) completely preempted this claim, it grounded its holding in its finding that the claim involved "core administrative function," the type of "pure eligibility decision" as defined by *Pegram*, not the type of treatment decision involved in *Dukes*. *Id.* at 274.

CIGNA and Aetna cite *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), for the proposition that Congress intended § 502(a)(1)(B)'s contract action to be the sole remedy available. They argue that patients must pay for services ahead of time and, if the plan administrator denies benefits, sue for reimbursement under § 502(a)(1)(B). Although *Pilot Life* includes some expansive language that arguably supports CIGNA and Aetna's reading,[14] the Supreme Court's most recent word on the matter,

[14] *See, e.g., Pilot Life*, 481 U.S. at 54, 107 S.Ct. 1549 ("[Congress's] inclusion of certain remedies and exclusion of others ... would be com-

Rush Prudential HMO, Inc. v. Moran, --- U.S. ----, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002), indicates *Pilot Life* does not sweep so broadly.

In *Pilot Life,* an ERISA participant who was denied benefits sued in state court, asserting common law contract claims. The Court held § 502(a)(1)(B) preempted the claim. ERISA provides a means of collecting benefits and set forth an exclusive list of remedies; states could not create alternative causes of action for collecting benefits that expanded upon ERISA's remedies. *Pilot Life,* 481 U.S. at 54-55, 107 S.Ct. 1549; *Rush Prudential,* 122 S.Ct. at 2166.

Since *Pilot Life,* the Supreme Court has "found only one other state law to 'conflict' with [§ 502(a)] in providing a prohibited alternative remedy." *Rush Prudential, id.* In *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), the Court held that "Texas's tort of wrongful discharge, turning on an employer's motivation to avoid paying pension benefits, conflicted with ERISA enforcement." *Rush Prudential,* 122 S.Ct. at 2166. The *Rush Prudential* Court explained its holding in *Ingersoll-Rand:* "[The] state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under § 1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." *Rush Prudential, id.*

We glean from *Rush Prudential* that *Pilot Life* 's rule is a narrow one: States may not duplicate the causes of action listed in ERISA § 502(a). This is, essentially, the test employed for "complete preemption." Because the THCLA

---

pletely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.... 'Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly' " (quoting *Mass. Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985))).

does not provide an action for collecting benefits, it is not preempted by § 502(a)(1)(B) under *Pilot Life*.

Any doubts we might have are eliminated by *Pegram* 's admonition that ERISA should not be interpreted to preempt state malpractice laws or to create a federal common law of medical malpractice. *See Pegram,* 530 U.S. at 236-37, 120 S.Ct. 2143. We decline, two years after the Court expressed disbelief that Congress would federalize medical malpractice law under § 502(a)(2), to hold that Congress has done so under § 502(a)(1)(B). Having concluded that § 502(a) does not completely preempt Calad's and Davila's THCLA claims, we vacate and remand to the district court for proceedings consistent with this decision.

B. Thorn's motion to remand

Aetna cross-appeals the decision to remand Thorn's claims to state court. Except for those cases removed pursuant to 28 U.S.C. § 1443, "[a]n order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise." 28 U.S.C. § 1447(d). On its face, this statute seems to deprive us of jurisdiction over Aetna's cross-appeal. But we read § 1447(d) in conjunction with § 1447(c)'s command that "[i]f at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded." 28 U.S.C. § 1367(c). Accordingly, § 1447(d) applies only where a district court remands for lack of subject matter jurisdiction; we may review remands based on other grounds. *Things Remembered v. Petrarca,* 516 U.S. 124, 127-28, 116 S.Ct. 494, 133 L.Ed.2d 461 (1995); *Giles,* 172 F.3d at 336.

Reviewable remand orders are a narrow class of cases, meaning we review a remand order only if the district court " 'clearly and affirmatively' relies on a non-§ 1447(c) basis."

Giles, 172 F.3d at 336. The district court explained that it had supplemental jurisdiction over Thorn's claim, but it was exercising its discretion under 28 U.S.C. § 1441(c) to remand. As in *Giles,* "the court affirmatively gave a non-§ 1447(c) reason for remanding and gave no indication that it believed it lacked subject matter jurisdiction." *Id.* Accordingly, "we review the district court's exercise of its discretion to remand supplemental ... state law claims." *Id.*

The district court held that even though Thorn stated only state law causes of action, it had supplemental jurisdiction over his claims, because they were joined to Calad's claims. Thus, the court's jurisdiction over Thorn's claims depended on its removal power over Calad's claims.[15] But, as we have explained, the district court never had removal jurisdiction over Calad's claims. Consequently, it never had subject matter over Thorn's claims, so remand was mandatory, not discretionary.[16]

C. The Roarks' motion to remand

The Roarks' original complaint, filed in state court, stated claims under the THCLA, the DTPA, the Texas Insurance Code, and common law breach of good faith, fair dealing, and contract. Humana removed, citing ERISA preemption, and the Roarks moved to remand. Only after the district court affirmed the removal, concluding ERISA § 502(a)

---

[15] *See* 28 U.S.C. § 1441(c) (hinging removal of supplemental claims on the existence of "a separate and independent claim or cause of action within the jurisdiction conferred by section 1331").

[16] *Avitts v. Amoco Prod. Co.,* 53 F.3d 690, 693 (5th Cir.1995) (explaining that if district court never had original jurisdiction over any federal claim, it could not have exercised supplemental jurisdiction over the joined state claims and was required to remand).

completely preempted the Roarks' DTPA and insurance claims, did the Roarks amend their complaint to state only THCLA claims. The Roarks made a second motion to remand, which the district court again denied; the Roarks appeal only the second denial.

If, at the time of removal, the complaint stated at least one cause of action completely preempted by § 502(a), the district court could have asserted jurisdiction over the entire case, including any claims only conflict- preempted by ERISA § 514 and any state law claims. *See* 28 U.S.C. § 1441(c),[17] *Giles*, 172 F.3d at 337-38.[18] Although the Roarks do not appeal the initial holding that § 502(a) completely preempts some of their original claims, we must examine it on our own initiative, because this question determines whether the district court had subject matter jurisdiction.

---

[17] Section 1447(c) provides,

> Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

28 U.S.C. § 1447(c).

[18] In *Giles* we explained,

> Hence, when a complaint raises state causes of action that are completely preempted, the district court may exercise removal jurisdiction. When a complaint contains only state causes of action that the defendant argues are merely conflict-preempted, the court must remand for want of subject matter jurisdiction. When a complaint raises both completely-preempted claims and arguably conflict-preempted claims, the court may exercise removal jurisdiction over the completely-preempted claims and supplemental jurisdiction (formerly known as "pendant jurisdiction") over the remaining claims.

Giles, 172 F.3d at 337-38.

McClelland, 155 F.3d at 511, 518 n. 39. We review this preemption question *de novo, id.* at 511, and conclude the district court did have jurisdiction .

Count six of the Roarks' original complaint alleges breach of contract: "By virtue of the policies provided to the Plaintiffs, Defendants assumed obligations, as outlined in the Member Materials and other documents provided to policy enrollees like the Roarks, to provide medically necessary treatment.... Defendants breached this promise to Mrs. Roark, causing her to suffer direct and serious damage." The Roarks assert that the plan's term "medically necessary treatment" includes VAC treatments.

The answer turns on interpreting the plan's language, not on applying an external, statutorily imposed standard of ordinary care. Because this is precisely the type of contract claim we recognize under § 502(a)(1)(B), *see supra* part II.A.2, this claim is completely preempted under ERISA.

This establishes that the district court had the power to entertain the Roarks' suit; it does not necessarily mean the court acted properly in doing so. The Roarks amended their complaint to state only THCLA claims, then filed a second remand motion, arguing that because all federal claims had been dismissed, 28 U.S.C. § 1367 required the court to remand the remaining supplemental state law claims. The district court ruled that the THCLA claims also were completely preempted under ERISA, so it had original jurisdiction over them and retained the case.

Because ERISA does not completely preempt the Roarks' THCLA claims, *see supra* part II, the district court had only supplemental, not original, jurisdiction over the Roarks' THCLA claims. "We review a district court's decision to retain jurisdiction over pendant [i.e., supplemental] state law claims for abuse of discretion." *McClelland,* 155 F.3d at 519; *see also* § 1367.

Section 1367(3) allows a district court to "decline to exercise supplemental jurisdiction over a claim ... if ... the district court has dismissed all claims over which it has original jurisdiction." 28 U.S.C. § 1367(3). The district court should evaluate whether remand furthers "the values of economy, convenience, fairness, and comity." *Carnegie-Mellon Univ. v. Cohill,* 484 U.S. 343, 351, 108 S.Ct. 614, 98 L.Ed.2d 720 (1988); *accord Brown v. Southwestern Bell Tel. Co.,* 901 F.2d 1250, 1254-55 (5th Cir.1990).

D. Dismissal of the Roarks' claims

The district court dismissed the Roarks' THCLA claims under rule 12(b)(6), citing ERISA § 514 preemption. We review a rule 12(b)(6) dismissal *de novo. E.g., Oliver v. Scott,* 276 F.3d 736, 740 (5th Cir.2002).

ERISA § 514 preempts "all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a). We have spilled much ink over the past few decades trying to interpret this statute. By contrast, our answer today is short and direct: Our decision in *Corcoran v. United HealthCare, Inc.,* 965 F.2d 1321 (5th Cir.1992), is on point. Although the Supreme Court has since cast doubt on *Corcoran* 's validity, we do not write on a clean slate. Our rule of orderliness prevents one panel from overturning the decision of a prior panel, so any relief for the Roarks must come from an en banc panel of this court or the Supreme Court. *Teague v. City of Flower Mound,* 179 F.3d 377, 383 (5th Cir.1999).

Corcoran is factually indistinguishable from the Roarks' case. There, the HMO ignored its doctor's recommendation to hospitalize Mrs. Corcoran or monitor her pregnancy around the clock; instead it provided the less expensive

treatment of ten hours a day of home nursing. *Corcoran,* 965 F.2d at 1324. While no nurse was on duty, Corcoran miscarried. *Id.* She sued her HMO, alleging its negligence caused her baby's wrongful death. *Id.*

We rejected both the HMO's "position that no part of its actions involve[d] medical decisions" and Corcoran's position "that no part of [her HMO's] actions involve[d] benefit determinations." *Id.* at 1332. In actuality, we explained, the HMO "makes benefit determinations as part and parcel of its mandate to decide what benefits are available under the [ERISA] plan." *Id.* "[F]rom this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination." *Id.*

Such a claim, we reluctantly concluded, was preempted under § 514. We recognized the possible harm our ruling created: ERISA provided no cause of action for medical malpractice; if ERISA also preempted all state medical malpractice claims, patients such as the Corcorans would be left with no remedy for potentially serious mistakes. *Id.* at 1338. But, we were bound by Supreme Court precedent, which at that time articulated an expansive view of ERISA preemption.

For example, we cited *Ingersoll-Rand* for the proposition that § 514's broad "relates to" language negated the normal rules of preemption. We would not assume that preemption was less likely in areas of "traditional state authority."[19] And, based on the broad language of *Pilot Life, Ingersoll-Rand,* and *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983), we concluded that even attenuated and indirect effects on an ERISA plan are enough

---

[19] *Corcoran,* 965 F.2d at 1334; *see also Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc.,* 793 F.2d 1456, 1468 (5th Cir.1986).

to bring a statute within § 514 preemption. *Corcoran,* 965 F.2d at 1328-29, 1338 n. 20.

Since then, the Supreme Court has curtailed the scope of § 514 preemption, most notably in a "trilogy" of cases between 1995 and 1997. The first case, *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), involved a New York statute requiring hospitals to collect surcharges from patients insured by a commercial carrier but exempting HMO's that provided open enrollment coverage. The Second Circuit had held that such surcharges "related to" ERISA plans: Many of these HMO's contracted with ERISA plans, and the surcharge, by affecting these HMO's' economic incentives, had an impact on plan structures.

The Court reversed in a unanimous opinion. The state statute's "indirect economic influence," the Court explained, "does not bind plan administrators to any particular choice." *Id.* at 659, 115 S.Ct. 1671. It only alters "the relative costs of competing insurance to provide them," *id.* at 660, 115 S.Ct. 1671, and this does not run afoul of ERISA preemption.

Two years later, a unanimous Court handed down *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.,* 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997). California had enacted a law that required payment of prevailing wages to employees in apprenticeship non-state approved programs but allowed lower wages for apprentices participating in state approved programs. The Court held that because the law was indifferent to ERISA coverage (state-approved programs did not have to be ERISA programs), the law did not make "reference to" such plans. *Id.* at 325, 117 S.Ct. 832.

The fact that "most state-approved apprenticeship programs ... appear to be ERISA programs" was immaterial. *Id.* at 327 n. 5, 117 S.Ct. 832. Nor did California's law have a "connection with" ERISA plans. It did not bind plans, le-

gally or practically, to a given result; it only provided economic incentives to alter their structure. *Id.* at 329, 117 S.Ct. 832. Most notably, the Court explicitly returned to a traditional preemption analysis: ERISA's "relates to" language did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by the Federal Act." *Id.* at 331, 117 S.Ct. 832 (internal quotation marks omitted).[20]

The last of the trilogy, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997), held that ERISA did not preempt New York's tax on gross receipts for patient services at health care facilities. The Court acknowledged that the tax had a direct effect on ERISA plans (in fact, it eschewed any distinction between direct and indirect effects), but still upheld the statute.

The trilogy undermines *Corcoran* in two important ways. First, the Court established that traditional preemption rules apply under ERISA. Thus, courts should presume ERISA does not preempt areas such as "general health care regulation, which historically has been a matter of local concern." *Travelers,* 514 U.S. at 661, 115 S.Ct. 1671. Second, the Court held that a state law's economic impact (direct or indirect) on plan structures is not enough to trigger § 514 preemption.

The Court's *dictum* in *Pegram* gives further reason to doubt that ERISA preempts medical malpractice claims such as the Roarks'. In holding that the plaintiff did not state a claim under § 502(a)(2), the Court, 530 U.S. at 236-37, 120

---

[20] Justice Scalia, in a concurrence in which Justice Ginsburg joined, urged the Court to "acknowledge[ ] that our first take on this statute was wrong; that the 'relate to' clause ... is meant, not to set forth a *test* for preemption, but rather to identify the field in which ordinary *field preemption* applies." *Id.* at 336, 117 S.Ct. 832 (Scalia, J., concurring).

S.Ct. 2143, expressed disbelief that ERISA preempts such claims:

> To be sure [*Travelers*] throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA.
>
> *Pegram,* 530 U.S. at 236-37, 120 S.Ct. 2143.

Furthermore, after *Pegram, Corcoran* 's rule creates perverse incentives for HMO's. If a doctor fails to recommend treatment, the patient may sue the doctor and HMO under state law. If the doctor recommends treatment, and the HMO denies coverage, the patient has no remedy. *Corcoran,* 965 F.2d at 1338. In this circuit, HMO's can escape all liability if they instruct their doctors to recommend every possible treatment and leave the real decision to HMO administrators. It is difficult to believe that one of Congress's goals in passing ERISA was to shift medical judgments from doctors to plan administrators.

If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by *Corcoran.* Accordingly, we affirm with respect to the Roarks.

In summary, the judgment in No. 01-10831, regarding the Roarks, is AFFIRMED. The judgment in No. 01-10891 is REVERSED in regard to Calad and AFFIRMED in regard to Thorn. The judgment in No. 01-10905 is REVERSED in regard to Davila. All these matters are REMANDED to the respective district courts for further proceedings, if any, that may be called for by this opinion.

APPENDIX B

Ruby R. CALAD and Walter Patrick Thorn, Plaintiffs,

v.

CIGNA HEALTHCARE OF TEXAS, INC. d/b/a Healthsource, et al., Defendants.

United States District Court, N.D. Texas, Dallas Division
No. CIV. 300-CV-2693-H.

June 21, 2001.

MEMORANDUM OPINION AND ORDER

SANDERS, Senior J.

Before the Court is the Plaintiffs' Motion to Remand, filed January 22, 2001; CIGNA's Response in Opposition, filed February 20, 2001; Aetna's Brief in Support of CIGNA's Notice of Removal, filed February 20, 2001; and Plaintiffs' separate Reply to each Response, both filed March 9, 2001. Since the close of pleadings, both sides have further filed various notices of new preemption authority, which the Court has considered. The Court heard oral arguments of counsel on the motion on April 20, 2001.

After considering the pleadings, the parties' briefs and supplemental materials, the arguments of counsel, and the relevant authorities the Court is of the opinion, for the reasons stated below, that Plaintiffs' Motion to Remand should be GRANTED in part and DENIED in part.

I. Background

Remand of this case turns on preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* Plaintiffs together brought a state-court action against their respective health maintenance organizations ("HMOs")[21] under the liability provisions of the Texas Health Care Liability Act ("THCLA"), TEX. CIV. PRAC. & REM. CODE ANN. § 88.001, *et seq.* (Vernon Supp.2001). More specifically, Plaintiffs plead a negligence cause of action under the statute, alleging that "Defendants failed to use ordinary care in influencing, controlling, participating in and making medical necessity decisions....which affected the quality of the diagnosis, care, and treatment provided to Plaintiffs." (Pet.¶ ¶ 27-28). Plaintiffs further plead gross negligence, alleging that Defendants put in place "a knowing, calculated scheme whereby the Defendants increased their profits by adversely affecting the medical care for patients such as [Plaintiffs] through the Defendants' own decisions regarding medical necessity." (Pet.¶ 36). As discussed more fully below, Plaintiffs each allege that the respective Defendants' medical necessity decisions wrongfully interfered with the recommendations of Plaintiffs' treating physicians, and that they suffered damages as a result. Plaintiff Calad challenges a medical necessity decision regarding the length of her hospital stay following surgery (Pet.¶ ¶ 3-4), and Plaintiff Thorn challenges the delayed approval of surgery following his injury in an accident (Pet.¶ ¶ 5-7).

The CIGNA Defendants timely removed the case to fed-

---

[21] Plaintiff Calad sued Defendants CIGNA HealthCare of Texas, Inc. d/b/a Healthsource and CIGNA Corporation (collectively, "CIGNA"). Plaintiff Thorn sued Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. (collectively, "Aetna").

eral court on December 11, 2000, pursuant to 28 U.S.C. § § 1441(a) and (b). CIGNA contends that Plaintiffs' state-law claims are all completely preempted by ERISA, *see* 29 U.S.C. § § 501, 502, and thus removable based on this Court's federal question jurisdiction, 28 U.S.C. § 1331. The Aetna Defendants subsequently joined in and consented to the removal, in a separate pleading filed December 12, 2000. (*See also* Defs.' Not. Removal ¶ 7).

II. Analysis

A. Federal Question Removal Under ERISA

CIGNA bears the burden of showing that its removal was proper and establishing this Court's jurisdiction over the case. The propriety of removal is determined by the complaint at the time of removal, and federal question jurisdiction generally turns on whether a federal question is presented on the face of a properly pleaded complaint. The well-pleaded complaint rule, however, is qualified by the doctrine of "complete preemption," which recognizes that "Congress may so completely preempt a particular area that any civil complaint raising [a] select group of claims is necessarily federal in character." *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 63-64 (1986).

In the context of ERISA, there are two types of preemption. First, if a claim seeks the type of relief provided through ERISA's exclusive civil enforcement provision, there is "complete preemption." This provision, Section 502(a) of ERISA, encompasses claims by an ERISA plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits

under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Second, there is so-called "conflict preemption" or "ordinary preemption" under Section 514(a) of ERISA, which preempts state laws insofar as they "relate to" an employee benefit plan covered by ERISA. 29 U.S.C. § 1144(a). As both sides acknowledge in this case, removal on federal question jurisdiction can only be based on Section 502(a) preemption. *See Copling v. The Container Store, Inc.*, 174 F.3d 590, 595 (5th Cir.1999); 29 U.S.C. § 1132(f).

As stated above, Section 502(a) preemption is a jurisdictional question, in which the Court must determine whether Plaintiffs are seeking the same relief as exclusively provided under the ERISA statute. "A case may be removed even if no federal claim is asserted in the complaint and federal preemption, raised as a defense, is the only issue of federal law implicated in the case." *Anderson v. Elec. Data Sys. Corp.*, 11 F.3d 1311, 1315 (5th Cir.1994) (citing *Taylor*, 481 U.S. at 62-64). A claim "within the scope" of Section 502(a) presents a federal question, and a basis for removal, no matter how artfully pleaded as a state cause of action. *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332, 337 (5th Cir.1999); *Heimann v. Nat'l Elevator Indus. Pension Fund*, 187 F.3d 493, 500-01 (5th Cir.1999).

The Court considers separately whether to remand the claims of each of the Plaintiffs.

B. Ruby Calad's Claims

1. Applicability of Section 502(a)

As a threshold matter, the Court considers the significance of the nature of CIGNA's role in Calad's claims, for purposes of Section 502(a) preemption. It is undisputed that

Calad's health care was provided by CIGNA under an ERISA- governed plan, made available to Calad through her husband's employer. Calad argues, however, that her state-law claim cannot be completely preempted because she sues her HMO, not the ERISA plan itself. CIGNA maintains that it (the HMO) performed various administrative functions in connection with the plan in Texas, including the provision of utilization review services and making benefit determinations under the plan. (CIGNA's Resp.App., Affidavit of John W. Wargo, ¶ 6). The Court concludes that ERISA's Section 502(a) remedial scheme extends not only to claims against ERISA plans, but also to claims against administrators of such plans, including providers of utilization review services, at the heart of Plaintiffs' claims in this case. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). The Court sees no reason to treat CIGNA differently in this regard, simply because the utilization review function is performed by personnel of the HMO rather than some third-party entity.

2. Complete Preemption

The Court's analysis focuses on whether Calad's purported quality-of- care claim against her HMO is properly read as a completely preempted federal claim. ERISA Section 502(a) provides the civil enforcement mechanism for claims arising from a denial of benefits or other coverage determination and thus completely preempts any state law cause of action seeking the same relief. *See Giles*, 172 F.3d at 336-37; *McClelland v. Gronwaldt*, 155 F.3d 507, 516-17 (5th Cir.1998). The Fifth Circuit employs a two-step analysis of "complete preemption," considering first whether the claim is subject to ordinary preemption under Section 514(a) and only then whether the claim falls within the scope of Section 502(a). *McClelland*, 155 F.3d at 517. Claims against

an HMO (or related managed care entity) for the manner in which it handled claims or for withholding of benefits or denial of a particular procedure have been held completely preempted. *See Rodriguez v. Pacificare of Texas, Inc.*, 980 F.2d 1014, 1017 (5th Cir.1993); *Corcoran*, 965 F.2d 1321 (5th Cir.1992). In basic terms, claims challenging the administration of a benefits plan and claims based upon a fai'ure to treat where the failure resulted from a determination that the requested treatment, or quantity of treatment, was not covered by the plan are preempted by ERISA. Claims challenging health care treatment decisions or the quality of care fall within the realm of negligence and medical malpractice, and are not preempted.

At the intersection of pure coverage claims and state law quality-of-care claims lie "medical necessity" or "utilization review" determinations by HMOs or related managed care entities, at issue in *Corcoran* and in this case. In *Corcoran*, the Fifth Circuit held preempted the plaintiffs' wrongful death claim, brought under Louisiana negligence law, against the ERISA plan administrator whose utilization review had denied pre-certification of hospitalization for Mrs. Corcoran, 965 F.2d 1321. Under a Section 514(a) analysis, the Fifth Circuit concluded that "[i]n our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the [ERISA] plan....The principle of *Pilot Life* that ERISA pre- empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here." *Id.* at 1332.

Calad brings a cause of action only under THCLA, and expressly denies that she seeks recovery of benefits under her ERISA plan. (Pet.¶ 34). Calad alleges that during "preauthorization and coverage procedures," CIGNA informed her that it authorized only one day of hospitalization following her scheduled surgery (a vaginal hysterectomy). (Pet.¶ 18). On the second day after the surgery, a hospital discharge

nurse, a CIGNA representative, allegedly informed Calad's treating physician (Dr. Estrada) that Calad must be discharged if she did not manifest hemorrhaging, fever or high blood pressure; absent any of these symptoms, Calad could extend her hospital stay only if she assumed the cost. (Pet.¶ 20). She "did not qualify under CIGNA's medical necessity criteria for continued hospital stay and was unable to incur the expense personally." (Pet.¶ ¶ 4, 21). Calad characterizes CIGNA's determination as "negligent adherence" to its medical necessity criteria (Pet.¶ 3), and further alleges that CIGNA "put in place and enforced their system of health care delivery" in a manner which was consciously indifferent to her rights, safety and welfare. (Pet.¶ 36).

Notwithstanding Calad's characterization of her claim as one arising under THCLA, the Court must determine whether her pleadings, fairly construed, challenge CIGNA's administration of plan benefits or the quality of care she received. The Texas statute provides for a negligence cause of action against HMOs and other managed care entities in certain circumstances.[22] The statute also expressly provides that the standard of care it establishes for treatment decisions creates no obligation on the part of HMOs or other managed care entities "to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity." TEX. CIV. PRAC. & REM. CODE § 88.002(d). The Fifth Circuit took note of this statutory disclaimer in its opinion last year reviewing a facial ERISA preemption challenge to

---

[22] Specifically, an HMO or other managed care entity has a duty to exercise ordinary care when making "health care treatment decisions" and is liable for damages for harm proximately caused to an insured or enrollee by the entity's breach of that duty. TEX. CIV. PRAC. & REM. CODE § 88.002(a). The statute defines such a decision as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." TEX. CIV. PRAC. & REM. CODE § 88.001(5).

the provisions of Section 88: "The provisions do not encompass claims based on a managed care entity's denial of coverage for a medical service recommended by the treating physician: that dispute is one over coverage, specifically excluded by the Act." *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526, 534 (5th Cir.2000) ("*Corporate Health I*").

Plaintiffs maintain that the managed care entities' determinations in their cases are "mixed medical decisions" outside the realm of ERISA preemption, relying on the Supreme Court's decision last term in *Pegram v. Herdrich*, 530 U.S. 211 (2000), and the oft-cited "trilogy" of Supreme Court cases that have limited somewhat the expansive scope of Section 514(a) preemption.[23] Plaintiffs correctly argue that the presumption is against ERISA preemption of state laws in areas which have traditionally been the domain of the states, such as health care regulation, unless Congress has clearly demonstrated an intent toward preemption. *See Travelers*, 514 U.S. at 654-55; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S.Ct. 1322 (2001).

The Court does not agree, however, that the Supreme Court's holding in *Pegram*, which was not a preemption case, compels the conclusion that utilization review determinations such as those made by CIGNA in this case are not preempted. The Fifth Circuit, in its opinion denying panel and en banc rehearing of *Corporate Health I*, did "not read

[23] *See De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997) (statute imposing tax on medical centers' gross receipts from patient services not preempted); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1995) (prevailing wage statute regarding public works contractors not preempted); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (statute regulating hospital rates for inpatient care, imposing surcharges on commercially insured patients but not on those insured by Blue Cross/Blue Shield or HMOs, not preempted).

Pegram to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise." *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 220 F.3d 641, 643-44 & n. 6 (5th Cir.2000) ("*Corporate Health II* "), *petition for cert. filed,* 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *see also Roark,* 2001 WL 585874, at *4 ("If [Calad] were suing [CIGNA] for breach of fiduciary duty under ERISA based on a mixed eligibility decision made by a [CIGNA] physician, *Pegram* would hold that [CIGNA] could not be held liable for breach of fiduciary duty because the decision was not a fiduciary decision under ERISA").

The Fifth Circuit has recently decided, post-trilogy and post-*Pegram,* the extent to which THCLA's provisions are preempted by ERISA. The court, reviewing under Section 514(a) analysis a facial challenge to the provisions of THCLA, concluded that the liability provisions of the Texas statute are not preempted. *Corporate Health I,* 215 F.3d at 534-35.[24] The court reasoned that the vicarious liability of the entity for the negligence of a treating physician does not "relate to" the managed care provider's role as an ERISA plan administrator so as to require preemption. *Id.* The panel reiterated that the state's efforts to regulate an entity in its capacity as plan administrator are preempted, while the entity's functions as a medical care provider are within the traditional sphere of state regulation. *Id.* at 534- 35 & n. 24 (noting *Corcoran* 's holding that medical decisions involving coverage determinations are preempted). Based on the Fifth

---

[24] The panel did find preempted Senate Bill 386's provisions, codified in the Texas Insurance Code, for independent review of medical necessity determinations by managed care entities, noting that they created a "quasi-administrative procedure for the review of such denial and bind the ERISA plan to the decision of the independent review organization." *Id.* at 539.

Circuit's reasoning in *Corporate Health* regarding Section 514(a) (non)preemption of certain portions of THCLA, including its discussion of the statutory disclaimer discussed above, the Court concludes that Calad's claims satisfy the preliminary inquiry--ordinary preemption--under *McClelland.*

At the heart of Plaintiffs' Motion to Remand is their extensive argument that, in light of *Pegram* and the trilogy, *Corcoran* is simply no longer good law. (Pls.' Reply Br. to Aetna, at 3-6; Oral Arg. Tr. at 31-32). Plaintiffs' fundamental problem, in this Court's view, is that *Corcoran* remains the law in the Fifth Circuit with respect to ERISA preemption of medical decisions made pursuant to utilization review. As Defendants point out, courts concluding that claims arising from a delay or denial of benefits are ERISA-preempted continue to cite the case with approval. *See, e.g., Pryzbowski v. U.S. Healthcare, Inc.,* 2001 WL 292997, at *11 (3rd Cir. Mar. 27, 2001); *Roark v. Humana, Inc.,* 2001 WL 585874, at *4 (N. D.Tex. May 25, 2001) (Fitzwater, J.); *Cristantielli v. Kaiser Found. Health Plan of Texas,* 113 F.Supp.2d 1055, 1063-64 (N. D.Tex.2000) (Solis, J.). Moreover, the Court concludes that the nature of Calad's claim distinguishes her case from others brought under THCLA and remanded to state court as quality-of-care claims. *See, e.g., Murray v. Huynh,* No. 00-CV-2161-R (N. D.Tex. Jan. 11, 2001) (Kaplan, J.); *Rice v. Kaiser Found. Health Plan of Texas, Inc.,* No. 99-CV-0714-L (N. D.Tex. Sept. 27, 2000) (Lindsay, J.); *Phommyvong v. Muniz,* No. 98-CV-0070-L, 1999 WL 155714 (N. D.Tex. Mar. 11, 1999) (Lindsay, J.).

Returning to Calad's pleadings, the Court concludes that, despite the negligence labeling under which she claims direct liability against her HMO under Texas law, Calad's claim is fundamentally one in which she challenges the quantity of care she received as a result of CIGNA's utilization review. To the extent that CIGNA's employee, agent or representa-

tive (as alleged here, CIGNA's hospital discharge nurse), may have "negligently adhered" to the HMO's medical necessity criteria, she was performing a function of ERISA plan administration. This is certainly the case with respect to the *pre-surgery* authorization of one day of hospitalization for Calad, which the Court notes is consistent with the ERISA plan's provisions.[25] Regarding the alleged *post-surgery* determination that Calad did not meet the criteria for additional hospitalization coverage,[26] the conclusion is ultimately the same. CIGNA's decision impacted on Calad's care, to the extent that any medical necessity determination impacts an insured; the decision, however, was essentially one regarding the amount and type of services for which Calad was covered under the plan.

The Court further notes that Calad has made no other allegation that can fairly be read to challenge the quality of the care she received. She has not claimed negligence by Dr. Estrada or by any other CIGNA personnel who participated in her treatment and decisions related to it. *See Roark*, 2001 WL 585874, at *3. Moreover, her allegations regarding CIGNA's implementation of its health care delivery systems, while couched in terms of negligence, instead reflect a claim regarding CIGNA's administration of benefits. The Court therefore concludes, completing the *McClelland* inquiry, that Calad's claims are within the scope of ERISA Section 502(a) and thus are completely preempted.

---

[25] The relevant plan documents indicate that only one day of hospitalization following the procedure (vaginal hysterectomy) is covered, unless certain symptoms were observed or the treating physician considered an additional stay necessary. (CIGNA's App. Supp. Resp. at 99).

[26] The Court notes that Calad alleges that her doctor's nurse assured her in advance that she could remain hospitalized if her doctor determined it was necessary (Pet.¶ 18), but she has not clearly alleged that her treating physician articulated such a recommendation after her surgery or otherwise attempted to override the determination of the discharge nurse.

Plaintiffs complain that Judge Higginbotham's two opinions in *Corporate Health* do not adequately address the authorities under which Plaintiffs challenge the ongoing validity of *Corcoran* and maintain that THCLA supports a direct liability cause of action against their HMOs. More specifically, Plaintiffs call for a more exhaustive examination of *Pegram*, the trilogy, and the legislative history of both ERISA and the Health Maintenance Organization Act of 1973. (Pls.' Br. Supp. Mot. Remand, at 14-17; Pls.' Reply Br. to CIGNA, at 3-6; Pls.' Reply Br. to Aetna, at 9-10). Plaintiffs seek, in the context of an as-applied challenge, further interpretation from the Fifth Circuit on whether THCLA claims arising from HMOs' medical necessity determinations are ERISA-preempted. This Court declines Plaintiffs' invitation to conclude that *Corcoran* is no longer good law in light of *Corporate Health* and the other authorities mentioned above, leaving this review appropriately to the appellate court.

For the reasons stated above, the Court concludes that Calad's claim brought under THCLA is, at bottom, not about quality of care but rather about her HMO's coverage determination and administration of her benefits. The Court therefore holds that Calad's claims against CIGNA are completely preempted and were properly removed under federal question jurisdiction; Plaintiff's Motion to Remand is therefore DENIED with respect to Calad's claims. Further, the Court notes that Calad has repeatedly made clear that, should the Court deny her motion to remand, she will not amend her pleading to bring an ERISA claim and therefore requests that her claims be dismissed. (Pls.' Reply Br. to CIGNA, at 2; Pls.' Reply Br. to Aetna, at 2-3; Oral Arg. Tr. at 5). Accordingly, Plaintiff Calad's claims are hereby DISMISSED WITH PREJUDICE.

C. Walter Thorn's Claims

As Plaintiffs point out, Aetna's consent to removal notwithstanding, Aetna itself could not have removed Thorn's claims against it. Thorn receives his health insurance through his employer, the Azle Independent School District. (Pet.¶ 22). The ERISA statute makes clear that the complete preemption provisions "shall not apply to any employee benefit plan if such plan is a governmental plan." 29 U.S.C. § 1003(b)(1). *See also* 29 U.S.C. § 1144 (ERISA's conflict-preemption provisions do not apply to any employee benefit plan exempt under Section § 1003(b)). The term "governmental plan" includes one "established or maintained for its employees ... by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing." 29 U.S.C. § 1002(32). ERISA, therefore, does not preempt Thorn's claims against Aetna.

The parties, however, have addressed various alternative bases for this Court to retain jurisdiction over Thorn's claims.[27] First, Defendants maintain that, the Court having proper removal jurisdiction over Calad's federal claim, it may exercise supplemental jurisdiction over Thorn's claim. *See Giles,* 172 F.3d at 337. In the context of its discretion regarding supplemental jurisdiction, the Court considers the relatedness of Calad's and Thorn's claims. Defendants argue that the Plaintiffs have only their counsel in common and that their claims were improperly joined to defeat preemption and federal jurisdiction (CIGNA's Resp. Br. at 5, 7-8). Plaintiffs maintain that Congress did not intend the inconsistent result that quality-of-care claims brought by ERISA plan beneficiaries (like Calad) are preempted, while nearly identical claims by beneficiaries of government plans (like Thorn) are not. (Pls.' Br. Supp. Mot. Remand, at 8-9). Given the plain statutory language exempting from ERISA coverage

---

[27] The Court notes here that federal question jurisdiction was the sole basis on which removal of this case was predicated. (CIGNA's Not. Removal ¶¶ 4-5).

governmental plans such as that in which Thorn participated, this Court declines to conclude that Congress could not have intended Calad's and Thorn's claims to fare differently under ERISA preemption analysis. This question of statutory interpretation and public policy is more appropriately left for the appellate court, in the larger context of defining the current state of the law on preemption of medical necessity decisions by managed care entities.

Second, at oral argument Defendants' counsel further contended that the Court properly has jurisdiction over Thorn's claim because the Plaintiffs' Petition alleges that Defendants are jointly and severally liable for the alleged damages to Plaintiffs. (Oral Arg. Tr. at 22). Although the allegations as pleaded at the time of removal are the proper basis for the Court's analysis of its removal jurisdiction, the Court considers Defendants' argument to be extremely thin support for jurisdiction over Thorn's claim, in the larger context of this case. Moreover, Plaintiffs' counsel on the record has expressly withdrawn Plaintiffs' allegations of joint and several liability against the respective Defendants, conceding that the inclusion of such allegations was a pleading error. (Oral Arg. Tr. at 32).

For the foregoing reasons, this Court concludes that Calad's claim is a separate and independent claim within the Court's federal question jurisdiction, joined with Thorn's otherwise non-removable claim. The Court hereby exercises its discretion to sever and remand Thorn's claim, which is governed by state law. *See* 28 U.S.C. § 1441(c).

III. Conclusion

For the foregoing reasons, the Court concludes that Plaintiff Calad's claims were properly removed, and the Motion to Remand is therefore DENIED with respect to Calad.

As requested in the alternative by Calad, her claims against CIGNA are DISMISSED WITH PREJUDICE. The Motion to Remand is GRANTED with respect to Plaintiff Thorn, and his claims are hereby REMANDED to the 162nd Judicial District Court of Dallas County, Texas.

SO ORDERED

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 01-10831

ROBERT ROARK; Robert Roark, on Behalf of the Estate of Gwen Roark, Plaintiffs-Appellants,

v.

HUMANA, INC.; Humana Health Plan of Texas, Inc., Doing Business as Humana Health Plan of Texas (Dallas), Doing Business as Humana Health Plan of Texas (San Antonio), Doing Business as Humana Health Plan of Texas (Corpus Christi); Humana HMO Texas, Inc., Defendants-Appellees.

Case No. 01-10891

RUBY R. CALAD, Plaintiff-Appellant-Cross-Appellee,

and

WALTER PATRICK THORN, Plaintiff-Cross-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INCORPORATED, Doing Business as Healthsource, Doing Business as Cigna Corporation, Defendant-Appellee,

AETNA U.S. HEALTHCARE; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants-Appellees-

Cross-Appellants.

No. 01-10905

JUAN DAVILA, Plaintiff-Appellant,

v.

AETNA U.S. HEALTHCARE, INC.; AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants-Appellees.

Sept. 17, 2002.

Appeals from the United States District Court for the Northern District of Texas, Dallas.

ON PETITIONS FOR REHEARING EN BANC

Before SMITH and BENAVIDES, Circuit Judges.*

PER CURIUM:

(X) Treating the Petitions for Rehearing En Banc filed by Cigna Healthcare o f Texas Incorporated and Robert Roark as Petitions for Panel Rehearing, the Petitions for Panel Rehearing are DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. APP. P. AND 5TH CIR. R. 35), the Petitions for Rehearing en Banc

are DENIED.

( ) Treating the Petitions for Rehearing En Banc filed by Cigna Healthcare o f Texas Incorporated and Robert Roark as Petitions for Panel Rehearing, the Petitions for Panel Rehearing are DENIED. The court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service not having voted in favor (FED. R. APP. P. AND 5TH CIR. R. 35), the Petitions for Rehearing en Banc are DENIED.

ENTERED FOR THE COURT:

/s/ JERRY E. SMITH

United States Circuit Judge

REHG-17a

*Judge Parker, a member of the panel, is retired and did nto participate in consideration of rehearing. This matter is decided by a quorum pursuant to 28 U.S.C. §46(d). Judge Jones is recused and did not participate in the consideration of rehearing.

APPENDIX D

TITLE 29 – LABOR

CHAPTER 18 – EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

SUBCHAPTER 1 – PROTECTION FO EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * * *

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c)

of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters

reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed

by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with section 101(i). For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the

administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reason-

able attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in

any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be

brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(*l*) Civil penalties on violations by fiduciaries

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

* * * * *

§ 1144. Other Laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section

1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded

by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section-

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or

program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

APPENDIX E

§ 88.001. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity" means any entity which deliv-

ers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

§ 88.002. Application

(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making

health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to

provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed

care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

§ 88.003. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with or otherwise complies with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsections (c) and (d).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health

maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under Subsection (c) as requested by a health insurance carrier, health maintenance organization, or managed care entity must be performed in accordance with Article 21.58C, Insurance Code. The health insurance carrier, health maintenance organization, or managed care entity requesting the review must agree to comply with Subdivisions (2), (3), and (4), Section 6A, Article 21.58A, Insurance Code.

(e) Subject to Subsection (f), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(f) The enrollee is not required to comply with Subsec-

tion (c) and no abatement or other order pursuant to Subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (e).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(h) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.